LETTERS *to the Editor*

Myelomeningocele

TO THE EDITOR: In the October, 1974, issue your journal carried an excellent symposium on myelomeningocele [Specht EE, Goodner EK, Tanagho EA, Prince B, Pevehouse BC, Cohen P: Myelomeningocele—A symposium on orthopedic, ophthalmologic, urologic, psychological and social, neurosurgical and general considerations (Pediatric Rounds). West J Med 121:281-304, Oct 1974]. It was noted in passing in the article by Dr. Cohen that there was a sixfold [recurrence] risk [of spina bifida cystica in a family after the birth of one such disabled child] compared with that in a normal family. Actually the recurrence risk appears to be 4 to 5 percent. It was not mentioned, and I feel it should have been, that because of this recurrence risk and because of the emotional components of having a disabled child, genetic counseling is often appropriate for these families. This, of course, requires that the physician caring for the patient thinks of this and is familiar with the local availability of such counseling. Also, I was somewhat disappointed that, although it has been two years since Brock and Sutcliffe reported the association between increased alpha-fetoprotein levels in the amniotic fluid and the presence of a fetus with a neural tube defect (Lancet 2:197, 1972), this relationship was not mentioned. It has since been firmly established that determination of the amniotic fluid alpha-fetoprotein level between 15 and 20 weeks of gestation makes possible the prenatal detection of neural tube malformations. I think that the possibility of such prenatal detection must be explained to each family with a child with a neural tube defect.

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TO THE EDITOR: I have read the myelomeningocele symposium published in the October, 1974, issue of THE WESTERN JOURNAL OF MEDICINE. In discussing the neurosurgical management of these cases, I think Dr. Pevehouse failed to emphasize the most important reason for closing a myelomeningocele, which is preservation of neurological function.

Anyone who has witnessed the delivery of children with myelomeningoceles will note that frequently the lesion is very flat upon delivery and the sac is unbroken. This is because intrauterine pressure keeps the neural tissue and the contents of the myelomeningocele in relatively proper position. Once the child is delivered, the atmospheric pressure is lower than the intrauterine pressure and the lesion expands. With the expansion of the lesion, increasing neurological deficit may occur, even though the child may seem neurologically intact at birth.

I would emphasize that closure of most myelomeningoceles is a true neurosurgical emergency and should be done as soon as possible after birth. If this is not feasible, some type of hyperbaric unit to enclose the lesion could be employed to keep the neural elements in anatomical position until definitive surgery can be performed.

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Screening Without Meaning

TO THE EDITOR: Entry of the Brown Bill (AB 2068) into the California Health and Safety Code as Chapter 1069 establishes a legislative and fiscal basis for implementing federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of children. Concerned physicians have emphasized that screening in the absence of a regular source of health care may be of no benefit to the patient (for example, Gershman M: Position on early and periodic screening [Letter to the Editor]. West J Med 121:69, Jul 1974). At the other end of the spectrum, when adequate care is being received through an established patient-provider relationship, an isolated screening program may do the patient a disservice by introducing duplication, with its attendant confusion and fractionation.

From the economic standpoint, AB 2068 requires development of community record systems "so that costly and unnecessary repetition of

screening will not occur." The following is an example of expensive duplication and fractionation of services, resulting from a well-intentioned screening effort that was not coordinated with existing arrangements for care.

Several pediatricians in this medical group received identical communications stating that patients regularly under their care had been enrolled in a medical screening project sponsored by a local school district, and that unless objection was received (in some instances within two days after the notice arrived), the patients would be scheduled for screening examinations. The program's medical consultant, who would "evaluate the child's need for care," was found to be a resident in pediatrics at a local medical center, which offered postscreening care to the participants "at clinic rates." Ironically, the children chosen for this isolated screening had been receiving continuity of care as members of a prepaid program which has long utilized multiphasic testing for children and adults[1,2] as part of a comprehensive health care system.

In 1973 Hass[3] urged that EPSDT not become a self-contained, isolated system, and outlined a practical method for fitting it within the scope of regular and continuous pediatric care. One approach would be to group the children of a given state into three categories. (1) Those already receiving care that meets or exceeds EPSDT requirements. For them, the provider might be required only to submit essential statistical data. (2) Children eligible for Medicaid who live in areas where care meeting EPSDT criteria is available, but not to them. Here, public welfare efforts could be directed toward identifying such children, interesting providers in seeing them and getting them to the providers. (3) Children living in areas that lack sufficient providers. For these, publicly supported programs might well make arrangements for screening, possibly through schools, and encourage providers to cover such districts. The last two needs cannot be met without adequate funding.

If EPSDT needlessly disrupts existing systems, duplication and expensive chaos can be anticipated. Laws mandating screening have been passed in the absence of evidence that screening programs in themselves can have a positive effect on health care. One of the greatest dangers of an isolated testing program is that screening could become an expensive and rigid goal in itself. Continuity of care is more important than specific screening tests. If screening is to have any meaning, it must be within an ongoing health program for the patient.

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